Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ADVANCED THERAPY SOLUTIONS
1530 SPRINGHILL RD, STE B
JASPER, TX 75951

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

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MFDR Tracking Number

M4-12-2256-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Texas Mutual is denying claims for past filing deadline in error. The claims in question were submitted through EMDEON on November 16, 2011. I have included a copy of the timely filing letter from EMDEON with this complaint showing that the claims were submitted and received by the payer on November 16, 2011. There are two sets of claims that were sent on the same day. One batch was for a total of $3,742.00 and the second batch was for $993.00. Both were denied. I submitted an appeal to Texas Mutual with the same information; proving that the claims were submitted in a timely manner, they maintained their first decision and again denied the claims as past filing. I spoke to Sylvia in the claims department and she told me that the only proof of timely filing that is accepted is from the clearing house that they use and that EMDEON was not acceptable to them."

Amount in Dispute: $2,497.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Review of the requestor's DWC-60 packet shows no untimely exceptions provided for under the Labor Code at 0408.0272. DWC MDR has stated that the evidence must satisfy the requirements of 28 TAC § 102.4(h). E.g.,MFDR #M4-10-2021-01. (Evidence of screen shots was not sufficient. Pursuant to § 102.4(h) there was no documentation found to sufficiently support that the medical bill was sent to the respondent within 95 days from the date the services were provided.)

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
08/15/2011 to 10/20/2011	97110-GP, G0283-GP, 97032-GP	$2,497.25	$1,087.17

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for Non-Commission Communications.
4. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement of Workers' Compensation Professional Services provided on or after March 1, 2008.
5. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
6. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
7. On 04/20/2012 MFDR was informed by the requestor that payment for DOS 09/29/2011, 10/04/2011, 10/06/2011, 10/11/2011, 10/13/2011, 10/18/2011 and 10/20/2011 was received from the respondent. Therefore, requestor is only disputing DOS 08/15/2011, 08/19/2011, 08/22/2011, 08/24/2011, 08/26/2011, 08/29/2011, 08/31/2011 and 09/02/2011.
8. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 02/20/2012
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - CAC-29- The time limit for filing has expired.
   - 724-No additional payment after a reconsideration of services. For information call 1-800-937-6824
   - 731-Per 133.20 Provider shall not submit a medical bill later than the 95th day after the date the service, For services on or after 9/1/05.

   Explanation of benefits dated 02/21/2012
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - CAC-29- The time limit for filing has expired.
   - 724-No additional payment after a reconsideration of services. For information call 1-800-937-6824
   - 731-Per 133.20 Provider shall not submit a medical bill later than the 95th day after the date the service, For services on or after 9/1/05.

   Explanation of benefits dated 01/25/2012
   - CAC-W1- Workers' Compensation State Fee Schedule Adjustment
   - CAC-29-The time limit for filing has expired.
   - 731-Per 133.20 provider shall not submit a medical bill later than the 95th day after the date the service, for services on or after 9/1/05

Issues

1. Did the requestor submit the medical bill for the services in dispute timely and in accordance with 28 Texas Administrative Code §133.20?
2. Did the requestor submit documentation to support the disputed bills were submitted timely in accordance with Texas Labor Code, Section §408.027 and 28 Texas Administrative Code §102.4?
3. Is the requestor entitled to reimbursement?

Findings

1. Pursuant to 28 Texas Administrative Code §133.20(b) states in pertinent part "Except as provided in Texas Labor code §408.0272…a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that Texas Labor Code §408.0272 applies to the service in dispute. For that reason, the requestor in this dispute was required to send the medical bill no later than 95 days after the service in dispute was provided. 28 Texas Administrative Code §102.4(h) states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus 5 days. If the date received minus five days is a Sunday or legal holiday, the date deemed

sent shall be the next previous day which is not a Sunday or legal holiday."

2. Review of the documentation submitted by the requestor finds 2 copies of an electronic bill submission report from Emdeon which supports that the requestor submitted the bills for the disputed services on 11/16/2011. The report also shows the bills were accepted by the respondent on the same date, 11/16/2011.
3. In accordance with Texas Labor Code §408.027, the Requestor has timely submitted bills to the respondent. Therefore, reimbursement is recommended per 28 Texas Administrative Code §134.203 as follows:

   CPT code 97110-GP: 54.54 WC CF/33.9764 Medicare CF x 28.74 Participating Amount= $46.13 x 20 units (8 DOS) = $922.60.

   CPT code G0283-GP: 54.54 WC CF/33.9764 Medicare CF x 12.20 Participating Amount=$19.58 x 7 units (7 DOS) = $137.06.

   CPT code 97032-GP: 54.54 WC CF/33.9764 Medicare CF x 17.14 Participating Amount= $27.51 (1 DOS)

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $1,087.17.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,087.17 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Patricia Rodriguez	
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.